

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043560

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128
FILED DEC 9 1963

Primary Registration District No. 2000

Registrar's No. 1715

STATE FILE NUMBER

VS 300
Rev. 4/59

1 0297

2 0530

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12 900

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WARREN	
b. CITY (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD		c. CITY OR TOWN CONWAY	
Length of stay in 1b 2 DAYS		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2037 N. LYON		d. STREET ADDRESS (If outside, give location) 3MI N.E.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TAMMY Middle MOAD Last MOAD		4. DATE OF DEATH Month DEC Day 3 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-13-1963
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME KENNETH MOAD		13b. MOTHER'S MAIDEN NAME MARY BUNCH	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT MARY BUNCH CONWAY RI.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO (b) (PROBABLY) PNEUMONIA DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 12-2-63 to 12-2-63 and last saw her alive on 12-2-63 Death occurred at 7:05 A m on 12-3-63 and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Erwin F Busiek MD		22b. ADDRESS 609 Cherry Springfield Missouri	
22c. DATE SIGNED 12-5-63		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 12-5-1963		23c. NAME OF CEMETERY OR CREMATORY GOOD SPRINGS	
23d. LOCATION (City, town, or county) WEBSTER Co Mo.		24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD	
25. DATE RECD. BY LOCAL REG. 12-6-63		26. REGISTRAR'S SIGNATURE Bernie Medley	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

12/3/63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bob Davis

Licensed Embalmer No. 5246

P. O. Address Menasha, Wis.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.